Minnesota Board of Pharmacy

DISCIPLINARY ACTIVITY: April through June, 2016.

The Board took the following disciplinary actions against **pharmacists** at its April and June, 2016 meetings:

Fargen, Dennis P., License # 112111. Mr. Fargen failed to catch a data entry error made by a technician and, as a result, a patient received a four-fold overdose of warfarin. During the investigation of this error, a Board of Pharmacy Surveyor discovered that Mr. Fargen was in violation of a number of statutes and rules governing the practice of pharmacy by: substituting a drug dosage which differed from the one ordered without permission of the prescriber; failing to provide patient counseling on all new prescriptions; failing to complete verification of a prescription drug order; failing to correctly complete certification of a filled prescription - by not reviewing a patient's medication profile for the purpose of conducting a prospective drug utilization review; logging into all of the pharmacy's computers using his credentials and then allowing other pharmacy staff to use the computers, resulting in the unique identifier of each individual involved in the dispensing process not being accurately recorded; and failing to maintain minimum standards for patient privacy by bringing prescriptions to his home in order to complete quality assurance. Consequently, the Board issued a Stipulation and Consent Order reprimanding Mr. Fargen, assessing a civil penalty in the amount of $2,500 and

requiring him to complete 10 hours of continuing education, consisting of a combination of education in patient safety and pharmacy law.

Halverson, Bryan D., License # 121123. In 2009, while still an intern, Dr. Halverson diverted expired drugs, including opioids, benzodiazepines and cocaine, from the pharmacy at which he worked. The drugs were marked for destruction and Licensee altered the destruction logs. After being licensed as a pharmacist, he diverted approximately 84 tablets of Lyrica from the pharmacy at which he worked (in 2014). He was unsatisfactorily discharged from the Health Professionals Services Program, after testing positive for the metabolites of ethanol. (September, 2015). Subsequent to his discharge from HPSP, he began to use marijuana and increased his consumption of alcohol. Consequently, the Board issued a Stipulation and Consent order, suspending his license to practice pharmacy. Dr. Halverson will be allowed to petition for reinstatement of his license after demonstrating at least 12 months of sobriety.

Hatch, Lana B., License # 117083. Ms. Hatch was the pharmacist-in-charge at a pharmacy where another pharmacist failed to catch a data entry error made by a technician and, as a result, a patient received a four-fold overdose of warfarin. During the investigation of this error, a Board of Pharmacy Surveyor discovered a number of violations of statutes and rules governing the practice of pharmacy including: pharmacists were not providing consultations for all new prescriptions; pharmacists were not documenting refusal of counseling; and quality assurance had not been completed on prescriptions for a period of approximately two years. Consequently, the Board issued a Stipulation and Consent Order reprimanding the licensee and assessing a civil penalty in the amount of $2,000.

Huppler, Edward G., License #113757. Mr. Huppler admitted to violating several provisions of statutes and rules related to the practice of pharmacy - involving the provision of central pharmacy services, the operation of a telepharmacy, the return of drugs from long-term care facilities, the processing of controlled substance prescriptions, and compounding. Consequently, the Board issued a Stipulation and Consent Order that reprimands Mr. Huppler, assesses a civil penalty of $10,000.00, requires the submission of certain policies and procedures, and requires him to take and pass the MPJE.

Johnson, William S., License # 112338. Mr. Johnson was the pharmacist-in-charge for a pharmacy located within Minnesota at which a patient received another patient's prescription on two occasions. This occurred because the other patient's prescriptions were placed in the first patient's bag. Mr. Johnson completed product verification and bagging for the prescriptions involved. The first patient's prescriptions were new, so counseling was mandatory - but there was no evidence that counseling had occurred. Mr. Johnson failed to follow the pharmacy's policies by not reporting these errors as either medication or HIPAA events. Consequently, the Board issued a Stipulation and Consent Order reprimanding Mr. Johnson, imposing a civil penalty of $1,000 and prohibiting him from serving as a pharmacist-in-charge for a period of five years.

The Board took the following disciplinary actions **pharmacies** at its March and June, 2016 meeting:

CVS Pharmacy #3313, License # 263176. Licensee was found to be in violation of several statutes and rules governing the operation of pharmacies in Minnesota:

pharmacists were not providing counseling on all new prescriptions - instead, technicians were making an "offer to counsel"; counseling refusals were not being documented by pharmacists; Licensee's pharmacy staff could not produce a copy of a current consultation policy that specifically addressed the requirements found in Minnesota Rules; beyond-use-dates were not being appropriately established for all compounded products; Licensee had one pharmacist on duty with four technicians - consequently, the Board asserts that the pharmacy exceeded the allowed technician-to-pharmacist ratio (but Licensee avers that the ratio was not exceeded). Consequently, the Board issued an order that reprimands Licensee and assesses a civil penalty in the amount of $7,500.

CVS Pharmacy #7060, License # 263337. A May, 2015 inspection by a Board of Pharmacy Surveyor revealed that quality assurance had not been completed by Licensee on prescriptions dating back to February, 2015. For prescriptions on which QA had been completed, there was no indication of the QA date. Other prescriptions had QA dates more than 72 hours after the prescription was filled. Consequently, the Board issued a Stipulation and Consent Order that reprimands Licensee and imposes a civil penalty in the amount of $7,500.

CVS Pharmacy #7117, License # 263339. Licensee was found to be in violation of a number of statutes and rules governing the operation of a pharmacy in Minnesota: pharmacists were not consistently providing consultation on all new prescriptions; consultation refusals were not being consistently documented by pharmacists; licensee's pharmacy staff could not produce a current consultation policy that specifically addressed requirements found in Minnesota Rules; Licensee's pharmacy staff were sharing initials or bar codes in order to bypass register prompts meant to ensure that pharmacists

consulted on new prescriptions; beyond-use-dates were not being appropriately established for all compounded products; and compounding log sheets were not being completely filled out. Consequently, the Board adopted a Stipulation and Consent Order that reprimanded licensee and imposed a civil penalty in the amount of $2,500.

CVS Pharmacy #7172, License # 263157. During a visit by Board Surveyors, Licensee had one float pharmacist on duty and with five technicians. Four of the technicians were involved in the dispensing process. Consequently, the Board asserts that Licensee exceeded the allowed technician-to-pharmacist ratio. Licensee avers that the ratio was not exceeded. The float pharmacist was the only pharmacist on duty and was scheduled to work a 13 hour shift. At or near the beginning of that shift, there were over 500 prescriptions in the work queue waiting to be filled. As of April 14, 2015, Licensee was behind on QA checks dating back to July, 2014 and the QA that was completed was not done within 72 hours of the prescription being filled or was only done sporadically. Between March 25, 2013 and April 1, 2015, at least four pharmacists were designated as pharmacists-in-charge for Licensee but Licensee did not notify the Board about any of these PIC changes. Consequently, the Board adopted a Stipulation and Consent Order that reprimanded the licensee and assessed a civil penalty in the amount of $20,000.

CVS Pharmacy #7406, License # 263384. During a routine inspection in June, 2015, a Board Surveyor noted: pharmacists were not providing counseling on all new prescriptions - instead technicians were making an "offer to consult;" consultation refusals were not being documented by pharmacists; Licensee's pharmacy staff could not produce a copy of a current consultation policy that specifically addressed the requirements found in Minnesota rules; beyond-use-dates were not being appropriately

established for all compounded products; testosterone powder, which is considered hazardous, was available for use in the pharmacy even though the pharmacy did not have the equipment necessary for hazardous compounding; outdated compounding supplies were found that had not been quarantined. Consequently, the Board issued a Stipulation and Consent Order, reprimanding the Licensee and assessing a civil penalty in the amount of $2,500.

Target Pharmacy #17278 (formerly T-2200), License # 264906 (formerly 262879). A patient received another patient's prescription on two occasions. This occurred because the other patient's prescriptions were placed in the first patient's bag. The pharmacist-in-charge completed product verification and bagging for the prescriptions involved. The first patient's prescriptions were new, so counseling was mandatory - but there was no evidence that counseling had occurred. The pharmacist-in-charge failed to follow the pharmacy's policies by not reporting these errors as either medication or HIPAA events. Consequently, the Board issued a Stipulation and Consent Order reprimanding the licensee and imposing a civil penalty of $1,000.

The Board took the following disciplinary actions involving a **pharmacy technician** at its January, 2016 meeting**:**

Her, My L., Registration # 710547. While working for a hospital pharmacy, Ms. Her was involved in the compounding of chemotherapy products. The hospital's policy for such compounding required technicians to take certain actions to ensure that proper stage-checking could be completed by a pharmacist (as required by the rules of the Board). This included taking unique photographs at various stages of the compounding

process. Ms. Her purposely failed to take such unique photographs, instead sending to the pharmacist the same photograph of a set of syringes - rather than photographs of the actual syringes used. Consequently, the Board issued a Stipulation and Consent Order, reprimanding the Registrant.